BHSF Form 1-MB
Rev. 05/07
Prior Issue Obsolete

Louisiana Medicaid
Medicare Savings Program Application

Use this application to apply for Medicaid to pay your Medicare premiums, co-pays, and/or deductibles. **You must have or be eligible to get Medicare Part A to get this type of Medicaid.** If you are married, your spouse who also has or is eligible to get Medicare Part A may apply on this form. This is a free program. It does not cover medicine.

To apply, you need to do these things:

1. **Fill out and sign this application.** Please print and use a black pen.
2. **Get the documents of proof.** Look on the last page for things you need to send us. Please trust that the information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.
3. **Get this application form to us right away.** We will give you extra time to send in the proofs.

What language do you speak best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____
What language do you write best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

1. Where did you get this application form?

❑ Medicaid Office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative
❑ Internet ❑ Food Stamps Office ❑ Health Unit ❑ Social Security Office
❑ Business (Store, Work) ❑ Festival/Health Fair ❑ Other _____

2. Tell us about you (the person applying).

Name (first, middle initial, last)_____

❑ Male ❑ Female Parish You Live In_____

Social Security Number_____Maiden Name _____

Date of Birth (month, day, year)_____

❑ Married and living with spouse ❑ Single ❑ Divorced ❑ Widow/Widower

Race/Ethnic Background: (You do not have to answer. Mark one or more.)

❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Hispanic or Latino
❑ Native Hawaiian or Pacific Islander

If you are not a U.S. citizen, are you a permanent resident? ❑ Yes – Fill Out Below ❑ No – Go to Question 3
Permanent Resident Card (green card) Number: A#_____

Date came to the U.S.:_____

Call us toll free if you need help with this application at 1-888-544-7996. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

3. Tell us how to reach you.

Mailing Address_____Apt/Lot_____

City_____ State_____ Zip Code_____

Home Address (if different)_____

City_____ State_____ Zip Code_____

Home Phone (_____)_____Cell Phone (_____)_____

Message Phone (_____)_____E-mail Address_____

Best Day and/or Time to Call Between Hours of 7 a.m. and 5 p.m._____

4. If you are married and living with your spouse, tell us about them in the spaces below. ❑ No Spouse Lives With You - Go to Question 5

Name (first, middle initial, last) _____ ❑ Male ❑ Female

Date of Birth (month, day, year)_____Social Security Number_____

Does your spouse want to apply for the Medicare Savings Program? ❑ Yes - Fill Out Below ❑ No - Go to Question 5 **(**They must have or be eligible to get Medicare Part A to get this type of Medicaid.)

Spouse's Race/Ethnic Background: (You do not have to answer. Mark one or more.)
❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native
❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander

If your spouse <u>is not</u> a U.S. citizen, are they a permanent resident? ❑ Yes – Fill Out Below
❑ No – Go to Question 5
Permanent Resident Card (green card) Number: A#_____
Date came to the U.S.: _____

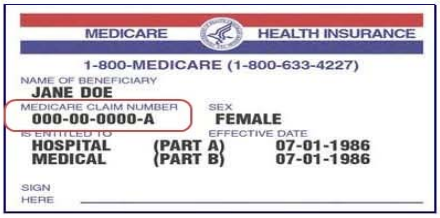
5. Medicare

Your Medicare Claim Number (on Medicare card)

_____

Your Spouse's Medicare Claim Number (on Medicare card)

_____


MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE

6. If anyone applying has health insurance or a Medicare supplement, answer the questions below. ❑ No Insurance - Go to Question 7

If there is more than one insurance, use another sheet of paper.

Who is covered? ❑ You ❑ Spouse ❑ Both Policyholder's Name _____

Coverage Start Date_____How much does it cost for the month? _____

Insurance Company Name and Phone Number_____

Insurance Company Address _____

Policy Number _____Group Number_____

What does it cover? ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance

7. Do you or your spouse work or are self-employed? ❑ Yes - Fill Out below ❑ No - Go to Question 8

Name of Working Person	Employer's Name _____ Employer's Phone Number ( ) _____ ❑ Self-employed	How much is paid (show gross, not take home pay)? $ _____ How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
Name of Working Person	Employer's Name _____ Employer's Phone Number ( ) _____ ❑ Self-employed	How much is paid (show gross, not take home pay)? $ _____ How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly

8. Does anyone get income (money) from:

• Social Security • SSI • Veterans' Benefits • Retirement • Pension • Royalties • Annuities • Rent from Property Owned • Alimony • Worker's Comp • Unemployment • Money from Friends/Relatives • Other (tell us what it is)

❑ Yes - Fill Out Below ❑ No - Go to Question 9

Name	Type of Income	How much is received? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.
Name	Type of Income	How much is received? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.
Name	Type of Income	How much is received? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.

9. Has anyone applied for income such as Social Security or Veterans' benefits, but they did not get it, yet? ❑ Yes - Fill Out Below ❑ No - Go to Question 10

Who?_____What is it? _____

10. If anyone who gets Social Security benefits ever received SSI benefits, but no longer gets SSI, now, give us their name. _____

11. Tell us if you or your spouse have any of the things listed below.

A. Checking/Savings account(s)? ❑ Yes – Fill Out Below ❑ No – Go to B
If there are more than 3 accounts, use another sheet of paper.

What is it? ❑ Checking ❑ Savings Who does it belong to? ❑ You ❑ Spouse ❑ Both
Name of the Bank _____
Account Number _____How much is in the account? _____

What is it? ❑ Checking ❑ Savings Who does it belong to? ❑ You ❑ Spouse ❑ Both
Name of the Bank _____
Account Number _____How much is in the account? _____

What is it? ❑ Checking ❑ Savings Who does it belong to? ❑ You ❑ Spouse ❑ Both
Name of the Bank _____
Account Number _____How much is in the account? _____

B. Money set aside in a bank account(s) for burial, or a pre-need (burial contract) with a funeral home? ❑ Yes – Fill Out Below ❑ No – Go to C

Who does it belong to? ❑ You ❑ Spouse ❑ Both
Name of the Bank or Funeral Home _____
How much is it worth? _____
If a pre-need, how was it funded? ❑ Cash ❑ Life Insurance ❑ Both
Is the pre-need paid in full? ❑ Yes ❑ No Can it be canceled or revoked? ❑ Yes ❑ No

C. Certificates of deposit (CDs)? ❑ Yes – Fill Out Below ❑ No – Go to D

Who does it belong to? ❑ You ❑ Spouse ❑ Both
Name of the Bank _____
Account number(s) _____
How much is it worth? _____

D. Bonds? ❑ Yes – Fill Out Below ❑ No – Go to E

Who does it belong to? ❑ You ❑ Spouse ❑ Both
What is the bond(s) worth? _____
Bond Number(s)_____
What type of bond is it? _____

E. Stocks? ❑ Yes – Fill Out Below ❑ No – Go to F

Who does it belong to? ❑ You ❑ Spouse ❑ Both
How much is the stock(s) worth? _____
What is the name of the company? _____

F. Annuities and/or retirement accounts (IRA, Keogh, 401-K)? ❑ Yes – Fill Out Below ❑ No – Go to G

Who does it belong to? ❑ You ❑ Spouse ❑ Both

Account Number(s)_____

How much is in it?_____

Are regular payments being received? ❑ Yes ❑ No

If **yes**, how much? $_____How often? _____

If **no**, are such payments available? ❑ Yes ❑ No ❑ Don't Know

Can a lump-sum withdrawal of these funds be made? ❑ Yes ❑ No ❑ Don't Know

G. Safety Deposit Box(es)? ❑ Yes – Fill Out Below ❑ No – Go to H

Who does it belong to? ❑ You ❑ Spouse ❑ Both

Name of the Bank_____

What is inside the box or boxes? _____

_____

What are the things inside the box worth? _____

_____

H. Life or burial insurance? ❑ Yes – Fill Out Below ❑ No – Go to I

Tell us about each policy. *If there are more than 8, use another sheet of paper.*

Policy Covers	Owner of Policy	Insurance Company	Face Value	Policy Number
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				
❑ You ❑ Spouse				

I. Cars, trucks, boats, campers, motorcycles, ATVs? ❑ Yes – Fill Out Below ❑ No – Go to J

Tell us about each below. *If there are more than 3, use another sheet of paper.*

Owner	What is it?	Make, Model, Year	What is it worth?	How much owed on it?

J. Property (not your home), like a second house, land, out of state property, or inherited property (can be undivided)? ❑ Yes – Fill Out Below ❑ No – Go to K

Who does it belong to? ❑ You ❑ Spouse ❑ Both

How much is it worth? _____

How much is owed on it? _____

Tell us about it (location, lot size, number of acres, buildings). _____

_____

K. Have you or your spouse ever created a trust, placed any items in trust, or has a trust set up for them? ❑ Yes – Fill Out Below ❑ No – Go to L

Date the trust was created._____Can it be revoked or canceled? ❑ Yes ❑ No

Was the trust set up by a Last Will and Testament? ❑ Yes ❑ No

Was the trust set up for a disabled person under age 65? ❑ Yes ❑ No

Who created the trust? _____

Who is the trustee? _____

L. Anything else? ❑ Yes – Fill Out Below ❑ No – Sign Application on Next Page

Who does it belong to? ❑ You ❑ Spouse ❑ Both

What is it? _____

How much is it worth? _____

Tell us about it. _____

This is the end of the application. You must sign the application on the next page.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) when someone moves in or out of the home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things owned by anyone who gets Medicaid who is disabled or over age 64.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

⬇ YOU MUST SIGN BELOW ⬇

Sign Your Name Here:_____ **Date** _____

If you are married and your spouse is applying, he/she will sign below.

Spouse Signs Here:_____ **Date** _____

If someone from Medicaid filled out this application for you, they will sign below.

_____ **Date**_____

Please mail, bring, or fax the application and proofs to your local Medicaid office right away. If you need the address or toll free fax number, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

Send Us These Things

These things are needed to help us see if you qualify. Some of these things will not apply to you and your spouse. For the things that do apply, let us know if you do not have or cannot get any of these things, because we may be able to get them ourselves or help you get them.

To help you decide what to send, enter a check ✓ next to each for the things that apply to you or your spouse.

❑ Copies of health insurance and Medicare Supplement cards (front and back) - for anyone applying

- ❑ Copy of Permanent Resident Card (green card) or other forms from U.S. Citizenship and Immigration Services - for anyone applying who is not a U.S. citizen
- ❑ If you or your spouse work, send pay stubs for the last month showing gross pay (before taxes) or letter from employer. If self-employed, send copies of tax return and all schedule attachments.
- ❑ Copy of Veterans' Benefit Award letter - for you and spouse
- ❑ Proof of any income such as retirement, pension, mineral rights, royalties, and any other income - for you and spouse
- ❑ If you or spouse own property that is rented out, send proof of the amount of rental income received (letter from renters or cancelled check).